Payment system for prescription drugs covered under Part B

Presentation to Senate Committee on Finance staff

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MEDPAC Medicare Payment Advisory Commission

Key points

- Drugs covered under Part B
- How the payment system works
- Issues
  - Current payment system leads to payments that overstate provider acquisition costs
  - Payment system can lead to higher prices
  - Payments for drug administration may be too low

Overview of sector in 2001

- Program spending of $6.4 billion
  - (about 3% of Medicare total)
  - Beneficiary responsible for 20% coinsurance
- About 450 drugs covered
- Annual growth rate of more than 20% for the past 3 years
  - Spending increased 26% from 2000-2001
- Payment system based on formula – 95% of Average Wholesale Price (AWP)

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Drugs covered under Part B

- Drugs are provided by physicians in their offices or pharmacy suppliers when used with DME
- Physician-billed drugs account for more than ¾ of program spending
- Spending is highly concentrated – top 10 drugs account for about 60% of total spending

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Covered drugs include:

- Drugs not usually self-administered
- Certain oral cancer and anti-nausea drugs
- Blood clotting factor
- Immunosuppressive drugs following organ transplants
- Epo for ESRD and cancer patients
- Drugs provided with DME

Top 10 drugs by expenditures, 2001

Name	Clinical indications	Type of competition
Non-ESRD epoetin alpha inj	Anemia	Multi-source
Leuprolide acetate	Prostate cancer	Sole-source
Ipratropium Bromide	Asthma and chronic lung disease	Generic
Goserelin acetate implant	Prostate cancer	Sole-source
Albuterol	Asthma and chronic lung disease	Generic
Paclitaxol	Cancer	Multi-source
Rituximab	Non-Hodgkin's lymphoma	Sole-source
Pamidronate disolium	Cancer-related	Sole-source
Infliximab	Rheumatoid arthritis; Chron's disease	Sole-source

Medicare payment formula

- Established in BBA
- For single-source drugs, 95% of Average Wholesale Price (AWP)
- For multi-source or generic drugs, 95% of the lower of
  - The median AWP of all generic forms of the drug
  - The lowest price brand name product

What is AWP?

- Can be thought of as manufacturer's suggested list price
- Drug pricing information is proprietary so AWP (which is public) has been used as a benchmark in negotiations by the industry
- AWP has never been defined in statute or regulation

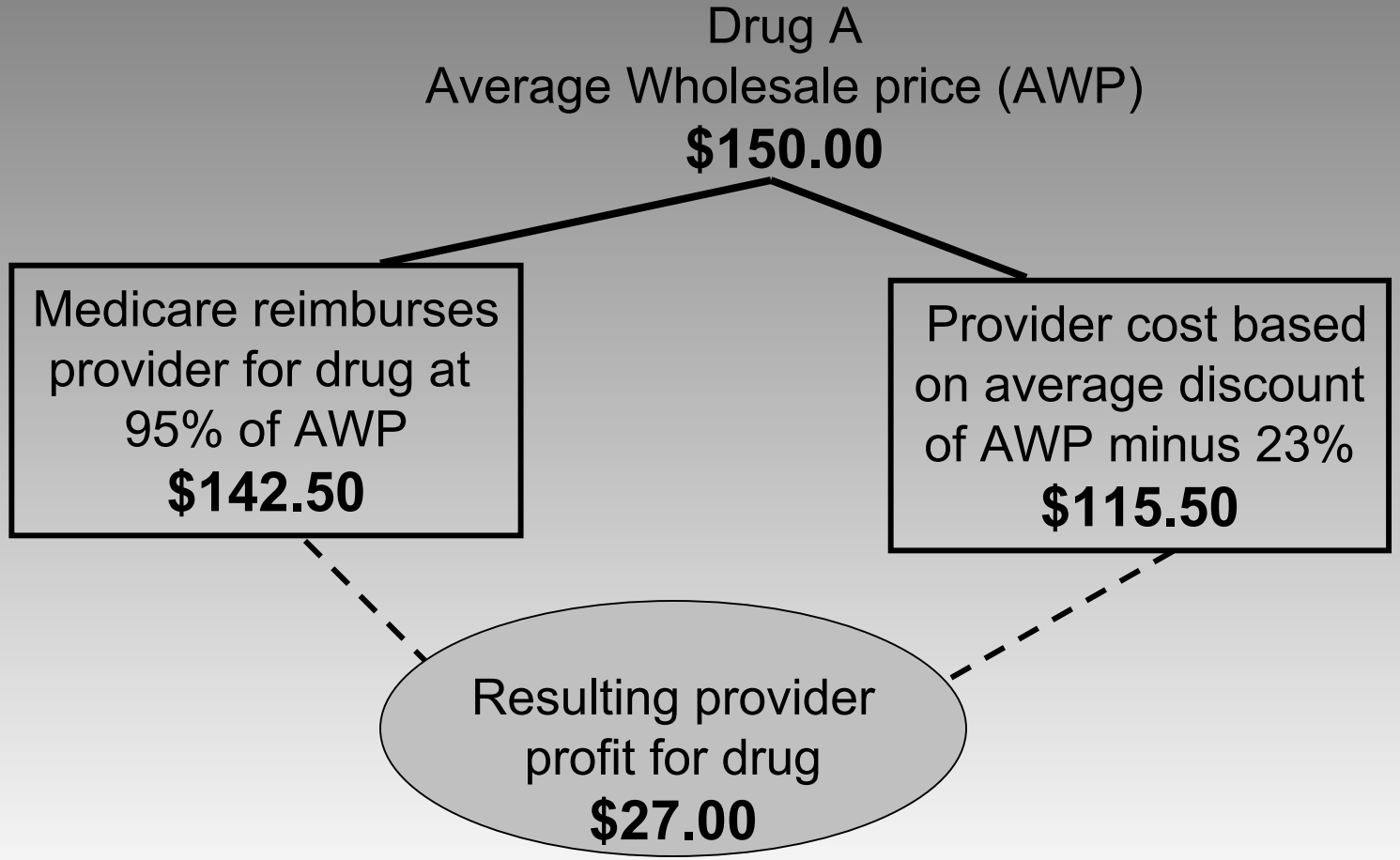
Drugs are available at prices well below AWP

- GAO found catalogue prices for drugs ranged from 13% to 86% below AWP
  - Medicare paid about $1 billion dollars above acquisition costs in 2000
  - These figures do not include rebates and other discounts widely available to providers
  - In some cases, beneficiary coinsurance was higher than acquisition costs

Current system provides incentives for higher prices

- Differences between AWP and acquisition costs are highest for products available from more than one source
  - 85% and 78% discounts for albuterol and ipratroprium bromide, most commonly billed pharmacy supplier drugs
  - Large spreads for single source drugs viewed as interchangeable by physicians

Medicare payment vs. Provider cost for Part B outpatient prescription drugs



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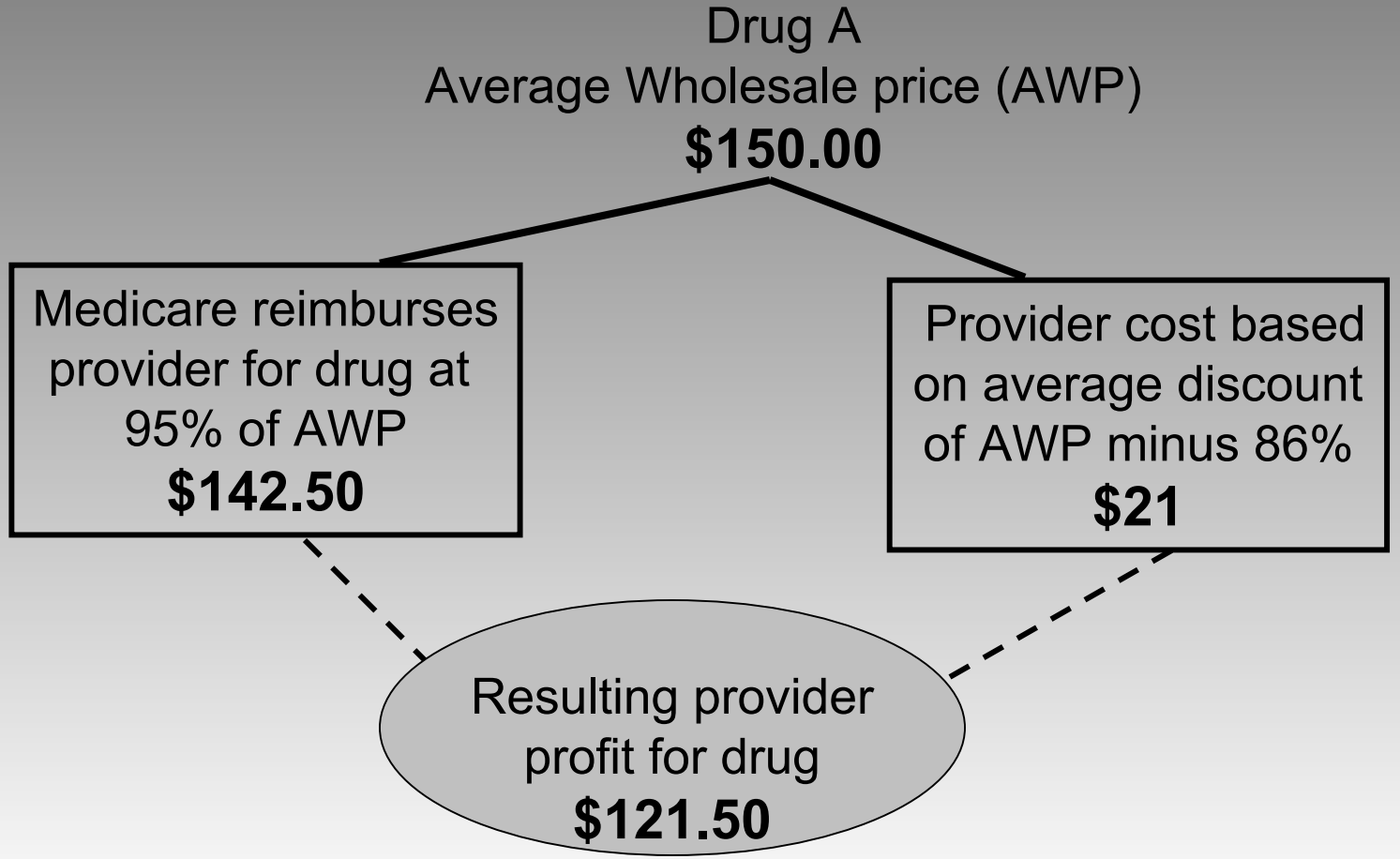
Medicare payment vs. Provider cost for drug with wide spread: An example



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Drug administration fees

- Medicare physician fee schedule includes fees for drug administration
- Pharmacy suppliers can bill for dispensing inhalation therapy drugs
- No administration fees for infusion therapy or covered oral drugs

Drug administration and practice expenses

- Components of practice expenses
  - Nonphysician staff
  - Rent
  - Equipment
  - Supplies

Payments for drug administration may be too low

- Practice expenses for administration of chemotherapy are underestimated
  - Supply expenses
  - Allocation of indirect expenses for nonphysician work
  - Unrepresentative 1998 survey used to calculate practice expenses for oncologists

Fixing administration fees

- CMS and GAO estimate practice expense fix for oncologists would cost about $50 million dollars
  - Difficult to fix administratively because of budget neutrality provisions
  - Other specialties would also be affected
  - Oncologists believe that these estimates do not take into account their true costs

Recent CMS actions

- Establishment of single drug price (SDP)
  - Choice of Palmetto GBA to calculate AWPs
  - Estimated savings - $50 mil/year
  - Further changes discussed – market survey to calculate AWPs ($500 mil/year)
- Concept of “functional equivalence”
- Rule on inherent reasonableness issued

New payment methods

- Most suggested alternative methods consist of two parts:
- Choosing a price measure to use for benchmarking
- Developing a payment method based on the benchmark

Alternative payment systems based on AWP

- Continue to use AWP as benchmark but reduce Medicare's costs
- Change the way AWP is calculated
- Increase the discount from AWP
- Require rebates from manufacturers
- Use inherent reasonableness authority

Alternatives based on different benchmark measures

- Replace AWP with a new benchmark which is:
- Based on actual transaction costs
- Is auditable
- Set payment method based on that benchmark

Additional alternative payment methods

- Competitive bidding
- Pay based on physician and supplier invoices
- Empower a commission to recommend payment updates

Issues to consider

- Does a proposed new method:
  - Affect beneficiary access
  - Affect site of care
  - Create new administrative burdens
  - Affect the prescription drug market
- Is it equally effective for all drugs?
- Does it require new legislation?